研究プロジェクト総合報告

The Effect of Community-Based Psycho-educational Program for Depression Prevention of Older Adults:

Comparison with Severity of Depression

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I. Introduction

Suicide rates of older adults make up over thirty percent of the total number of suicides and suicide rate of people over 50 years old is increasing in Japan (National Police Agency, 2012). A major cause of suicide among older adults is depression (Conwell et al. 1996), but effective intervention for prevention depression for older adults had yet remains a much-neglected area. In recent year, the number of older adults with subthreshold depression that do not fit the standards of diagnosis is increasing. Subthreshold depression has been shown to be correlated to the onset of cognitive impairment thus making early detection of symptoms as well as appropriate treatments important for preventive care for older adults (Cuijpers et. al., 2007).

Taking these findings into account, in recent years community-based suicide prevention programs for older adults has been implemented. Prevention interventions are divided broadly into five: interventions that gain the competency and skill of care managers (nurses, psychologists or social workers), community-based interventions that build a support system and provide psychiatric treatment to older adults who are high-risk and/or depressed, interventions that provide continuous support through telephone counseling, interventions that provide medication and psychological treatment to depressed older adults and interventions for improving resilience. Empirical studies of these programs showed effectiveness of intervention on suicidal ideation, suicide rate and depression. Moreover threes interventions aimed to reduce suicidal risk by gaining the knowledge about risk factors for older adults (Lapierre et al., 2011).

The systematic review showed psycho-education focused on gaining the knowledge about psychological risk on aging and the skill of self-management is effective on improving the symptoms of depression and prevention depression (Cuijpers et. al., 2007). Many studies indicated that cognitive behavioral therapy is especially effective

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in alleviating depressive thoughts in older adults with low cognitive impairment[25]. In terms of subthreshold depression, interventions based on cognitive behavioral therapy have been shown to be effective in improving mood and preventing major depression in the future. On cognitive behavior therapy, psycho- education can be effective in treating the negative stereotypes that older adults hold tied to changes with aging (Laidlaw, 2001), which is a risk factor in depression among older adults (Laidlaw, et. al., 2004). In many situations, treating depression in older adults requires medical treatment through the administration of drugs but psycho-education can be used in addition to medication (Baltes, 1996).

In studies that measured the correlation of health with cognition and emotion in older adults found that a change in health is a risk factor for thoughts that are harmful to emotions. There does not seem to be a direct effect from contracting a disease or decline in physical functioning leading to depressive thoughts. To build an adaptive mind that can handle changes in health or physical functioning, psycho-education also can be effective.

This study implemented the psycho-educational program for older adults who are community residences. The purposes of this study are to developing the psycho-educational program for Japanese older adults and verify the effect of the intervention on the improvement of depressed moods and knowledge concerning about self management of depression.

II. Method

1. Participants

Subjects for this study are residents ages 65 to 80 who are living independently in Kyotanabe-city, Kyoto prefecture, Japan. Subjects were recruited to participate in the program and respond to the questionnaire through advertisements in the city's community newspaper and community notices. The participants of control group were members of senior human resource center association. They received verbal and written instructions concerning the purpose of the study and provided written consent during the first (pre-test) of three questionnaires. Subjects completed the questionnaires on their own. The control group received a five hundred yen payment for each completed questionnaire.

Fifty-one older adult participants between the ages of 65 and 80 were assigned in the depression prevention psycho-educational program. During the intervention period, six participants (11.8%) dropped out and six participants (11.8%) were not able to complete the questionnaire. Out of the thirty-nine participants, fifteen participants (three men, twelve women, mean age=76.0±3.0 years) had a SDS score over 40 points and were placed in the high-risk group. Twenty-four participants (three men, twenty-one women, mean age= 73.2±4.9 years) comprised the low-risk group. Thirty participants in the control group answered the pre-test questionnaire, but four participants (13.3%) did not provide complete responses to the follow-up. Therefore, twenty-six participants in the control group were subject to the analysis. Out of the twenty-six participants in the control group, eight participants (three

men, five women, mean age=69.5±3.2 years) were in the high-risk group while eighteen older adults (three men, fifteen women, mean age= 73.6±4.1) comprised the low-risk group.

2. Measurement Scale

As indicator for depression, a self-rating depression scale SDS (Zung Self-rating Depression Scale, Zung, 1967) was used. The SDS is divided into three criteria: "pervasive affect," "psychological concomitants" and "physiological concomitants." The scale is composed of 20 multiple choice question items with the following four answer choices: "none/a little of the time," "some of the time," "a good part of the time" and "most of the time." A higher score denotes a higher level of depression. The FEQ (Fordyce Emotions Questionnaire, Fordyce, 1988) was utilized to rate emotional well-being. Current levels of happiness were rated on an 11-point scale ranging from "very happy" to "completely unhappy."

The measurement scale for knowledge concerning depression prevention was comprised of the following seven question topics: 1. Knowledge about depression; 2. How to prevent depression; 3. Possibilities for prevention; 4. Seeing the doctor for treatment; 5. Using the advice center in the city hall; 6. Doing something for prevention; and 7. Self-efficacy in prevention. Question items for each topic were created. Four-choice answers consisting of "totally disagree," "somewhat disagree," "somewhat agree" and "totally agree" were used for the following topics: 1. Knowledge about depression; 3. Possibilities for prevention; 4. Seeing the doctor for treatment; and 7. Self-efficacy in prevention. Four-choice answers consisting of "completely do not know," somewhat do not know," "know somewhat," and "know completely" were used for the following topics: 2. How to prevent depression; and 5. Seeing the doctor for treatment. Four-choice answers consisting of "not doing anything at all," "not doing much," "sometimes doing something" and "frequently doing something" was utilized for 6. Doing something for prevention.

3. Procedure

The intervention group received a psycho-educational program to promote psychological well-being and prevent depression in older adults. The treatment program focused on the following four factors: environment, lifestyle, self-awareness of quality of life, and mood. The program is a psychological intervention based on cognitive behavioral therapy and aimed to teach effective ways to improve mood through enhancing awareness of the relationships between mood with lifestyle, environment, and ways of thinking. Subjects who desired to participate in the program received information regarding the program specifics, timeline of the program, purpose of the program, and research procedures (pre-test, post-test, follow-up) from a public health nurse or trained student. For those who wished to participate in the study and provided consent after receiving the instructions and explanation, a written consent form and the first questionnaire was asked to be completed. The program session began following the pre-test.

The psycho-educational program for depression prevention was conducted in groups of seven to fifteen people and consisted of weekly sessions of 120 minutes for six weeks in the community center of Kyotanabe city. Table 1 displays the purpose

and specifics of each program session. The course of the program is as follows: introduction of the program and motivating to participate in the group, self-monitoring of mood, understanding of behavioral patterns that promote mood swings and the thought process affecting those behaviors, behavioral changes from changes in thinking, changes in one's environment, and prevention of relapses. Specifically, a lifestyle recording device was used to monitor and promote the understanding of the relationship between mood and behaviors. An exercise amount was set according to the subject's moods recorded from the device. Sleep patterns and activity plans were also reviewed and newly created. Chronic diseases and physical problems were also discussed. During the sessions, the subject's issues concerning living environment and social interactions were analyzed to determine the subject's needs and to improve the subject's environment. For subjects who needed to alter their environments, they were introduced to places where they could become socially active or social work services that they could utilize. Obstructive thoughts to positive alterations to the environment or activity levels were identified and adjustments were made to promote proper ways of thinking. New findings from alterations to the environment or activity levels were reviewed. The rating of quality of life was promoted by having the subjects exchange opinions among themselves during the sessions so they could subjectively rate their current situations. As part of the program, cognitive behavioral techniques were included to teach how to become aware of and adjust maladaptive emotions. Relaxation and assertive training sessions were also conducted. The emotional changes that correlate with cognitive and behavioral changes were confirmed with the subjects.

The psycho-educational program for depression prevention contained a 20 minute presentation during each session which provided information related to depression prevention. Taking into consideration the cognitive changes that occur with old age, the presentations utilized visual aids, role plays and texts. Each session consisted of the following issues: 1. Review of the homework; 2. Orientation of the today's session; 3. Teaching/Presentation; 4. Discussion/Group work 5. Feedback; 6. Self monitoring; 7. Explanation of home work for next session (Kusaka, 2008, 2009, 2010). The specifics of each individual program were interactive in that the subjects were informed about the process of treatment according to their needs. The goal of the program was to improve the subjects' moods as well as self-management of changes to their moods. During the last session, assessments and feedback of the effects of treatment were discussed along with the usability of the program's teachings during everyday life. Also, new issues were discussed and information regarding depression prevention was provided. The program was held at community centers or social service centers within the city where subjects could access by walking or bus.

The program was overseen by a clinical psychologist and assisted by trained student staff. Activity plan creations and health discussions were held with community nurses and psychotherapists. The social workers cooperated to provide information regarding the utilization social services.

This study conducted three questionnaires: pre-test before the program, post-test after

the last session, and follow-up one month after the last session. The control group subjects responded to the questionnaires at the same time as the intervention subjects. This study conducted the program on four different groups over the course of three and a half years.

Table 1. The process of psycho-education program

session	Strategies covered
1	Making acquaintance with the participants Information on the program in order to encourage an active participation to the process
2	Introduction/ Knowing each participants **Psycho-education** -Introduce mood rating system -Outline relationship between mood and behavior
3	**Psycho-education/ Behavioral intervention** -Identifying connections between mood and activity levels -Establishment of activity scheduling -Identifying obstacles to engaging in pleasant events
4	**Psycho-education/ Cognitive intervention** -Identifying negative automatic thoughts -Dealing with age-related negative automatic thoughts -Challenging unhelpful and unrealistic thoughts
5	**Problem-solving techniques** -Assertion training -Managing worry (thought stopping, using imagery)
6	**Psycho-education: Using the services** -Guidance by public health nurse about services -Self management and prevention **Self monitoring about participating in program**

III. Results

1. High-risk group

For the comparison of age in the high-risk intervention and control groups, a no treatment t-test was utilized. For the comparison of gender, Fisher's exact test was utilized. A significant difference between the intervention and control groups was not found for gender, but was found for age ($p < 0.001$). The reason may be due to the fact that incomplete answers from the control group were found mostly in older adults.

A comparison was conducted for the pre-test SDS score values between intervention and control groups using a no treatment t-test. A significant difference was not observed for the total scores, but for the "pervasive affect" question item, the control group scored significantly higher ($p < 0.05$). There was no significant difference for pre-test scores for happiness. The control group scored significantly higher ($p < 0.05$) for "possibilities for depression prevention" within the knowledge category. No significant difference was observed for pre-test scores in other question items.

According to two-way *ANOVA* on SDS scores, there was a significant interaction ($p < 0.01$) between group and survey period. More specific analysis in the intervention group demonstrated that a significant decrease in SDS scores occurred going from pre, post, and follow-up surveys. Among the items that make up the SDS score, "physiological concomitants" and "psychological concomitants" held a significant interaction ($p < 0.05$). Specific analysis in the active group demonstrated that a significant decrease ($p < 0.05$) in SDS scores occurred going from pre, post, and follow-up surveys (Table 2).

There was a significant interaction ($p < 0.01$) between group and survey period in regards to happiness scores. More specific analysis demonstrated a significant increase ($p < 0.05$) from pre-test to post-test results. A significant decrease ($p < 0.05$) was detected from post-survey to follow-up results (Table 2).

A significant interaction ($p < 0.01$) was found between group and survey period for the following knowledge question items: "possibilities for depression prevention," "using the advice center in the city hall," and "self-efficacy in prevention." More specific analysis demonstrated a significant increase ($p < 0.05$) from pre-test, post-test, to follow-up results in the intervention group for "possibilities for depression prevention" and "using the advice center in the city hall" . On the other hand, a significant decrease ($p < 0.05$) was found from post-test to follow-up results for "self-efficacy in prevention." Although a significant interaction was not found, an increasing trend was observed from pre-test to post-test for "knowledge about depression" and "doing something for prevention."

2. Low-risk group

A no treatment t-test was utilized to compare age between the intervention and control groups within the low-risk group. *Fisher's exact test* was utilized to compare age. No significant difference in age or gender was found between the intervention and control groups within the low-risk group. No significant difference was found between initial values of SDS total scores. However, for the "pervasive affect" question items, the non-intervention group scored higher ($p < 0.05$) while for the "physiological concomitants" question items, the intervention group scored higher ($p < 0.01$). No significant difference was found for initial values of happiness scores. Within the knowledge questions, the intervention group scored higher ($p < 0.05$) for the question item "knowledge about depression." No other question items had a significant difference between initial values.

According to two-way *ANOVA* on SDS scores, there was a significant interaction ($p < 0.01$) between group and survey period. More specific analysis revealed that scores significantly decreased ($p < 0.05$) in the intervention group from the pre-test, post-test to follow-up. Among the SDS score components, a significant interaction ($p < 0.05$) was found between "physiological concomitants" and "psychological concomitants." More specific analysis revealed that in the intervention group, a significant decrease ($p < 0.05$) occurred from pre-test to post-test for "psychological concomitants" (Table 1). A significant interaction ($p < 0.01$) was found between group and survey period for happiness scores. More specific analysis revealed that in the intervention group, a significant increase ($p < 0.05$) occurred from pre-test, post-test, to follow-up (Table 2).

A significant interaction ($p < 0.05$) was found between group and survey period for the following knowledge question items: "knowledge concerning possibilities for depression prevention," "possibilities for depression prevention," "using the advice center in the city hall," "doing something for prevention," and "self-efficacy in prevention." More specific analysis revealed that a significant increase ($p < 0.05$) was found from pre-test, post-test to follow-up in the following question items: "knowledge concerning possibilities for depression prevention," "possibilities for depression prevention," and "using the advice center in the city hall." A significant increase ($p < 0.05$) was found for "doing something for prevention" and "self-efficacy in prevention" ($p < 0.05$).

IV. Discussion

This study examined the effect of a psycho-educational program strongly focused on improving self management skills by the understanding of depression and depression prevention among community older adults. Results indicated that in both the high-risk and low-risk groups, program participants demonstrated an improvement in depression and happiness while increasing the amount of knowledge concerning depression

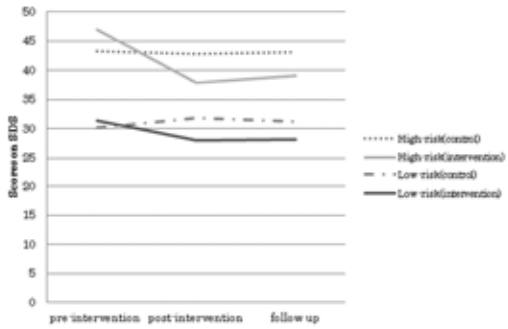

Figure 1. Differences in Scores on the Zung Self-rating Depression Scale (SDS)

Table 2. Means and standard deviations of variables for intervention and control groups

	Control group			Intervention group			*ANOVA*	
	Pre	Post	Follow	Pre	Post	Follow	*F*	*P*
High-risk group								
n (male / female)	8 (3/5)			15 (3/12)				
Age	69.5 (3.2)			76.0 (3.0)				
SDS (Depression)								
Total score of SDS	43.3 (2.9)	42.8 (6.6)	43.1 (5.6)	47.0 (5.3)	37.9 (7.2)*	39.1 (6.3)*	7.45	0.0017
Pervasive affect	3.9 (0.6)	3.6 (0.7)	3.8 (0.7)	2.8 (1.1)	2.4 (0.8)	2.3 (0.5)	0.27	0.7650
Psychological concomitant	15.6 (2.9)	16.1 (3.2)	15.1 (2.4)	17.3 (2.6)	14.2 (2.0)*	13.5 (2.5)*	4.73	0.0141
Physiological concomitants	23.8 (3.2)	23.0 (5.5)	24.3 (5.3)	26.9 (4.1)	21.3 (6.9)*	23.3 (5.1)*	3.49	0.0398
FEQ (Happiness)	1.5 (1.2)	-0.1 (2.5)	0.3 (2.4)	2.1 (2.1)	4.0 (1.4)*	2.7 (1.3)†	5.24	0.0093
KPDS (Knowledge)								
Knowledge about depression	3.3 (0.7)	3.0 (0.8)	2.9 (0.6)	2.8 (0.9)	3.7 (0.9)*	3.1 (0.7)	3.04	0.0585
How to prevent depression	2.4 (0.9)	2.4 (0.7)	2.3 (0.7)	1.9 (1.0)	3.2 (0.9)*	2.8 (0.9)*	4.71	0.0143
Possibilities for prevention	3.0 (0.5)	2.9 (0.4)	3.0 (0.5)	2.9 (1.1)	3.6 (0.8)	3.3 (0.5)	1.98	0.1509
Seeing the doctor for treatment	3.3 (0.9)	3.3 (1.2)	3.3 (0.9)	3.1 (1.0)	3.8 (0.4)	3.5 (1.1)	1.11	0.3391
Using the advice center in the city hall	3.4 (1.3)	2.6 (1.3)	3.0 (0.9)	1.9 (1.1)	3.5 (1.1)*	2.9 (1.0)*	3.62	0.0355
Doing something for prevention	2.4 (0.7)	2.5 (0.5)	2.6 (0.5)	1.9 (1.2)	3.3 (1.0)*	2.9 (1.0)	2.85	0.0693
Self-efficacy in prevention	2.9 (0.4)	2.8 (0.5)	3.0 (0.0)	2.9 (1.1)	3.5 (0.6)	2.7 (0.7)†	3.47	0.0403
Low-risk group								
n (male / female)	18 (3/15)			24 (3/21)				
Age	73.6 (4.1)			73.2 (4.9)				
SDS (Depression)								
Total score of SDS	30.2 (4.6)	31.8 (8.7)	31.3 (8.7)	31.4 (4.6)	28.0 (4.1)*	28.1 (6.0)*	6.21	0.0031
Pervasive affect	2.6 (0.7)	2.8 (1.1)	2.7 (0.9)	2.2 (0.5)	2.2 (0.4)	2.3 (0.6)	0.44	0.6459
Psychological concomitant	11.4 (1.6)	12.3 (2.4)	11.6 (2.1)	13.6 (2.8)	12.5 (3.0)	11.9 (3.4)	3.17	0.0475
Physiological concomitants	16.3 (3.4)	16.8 (5.6)	17.0 (6.2)	15.6 (3.3)	13.3 (2.3)*	13.9 (3.6)	4.07	0.0208
FEQ (Happiness)	2.7 (2.3)	2.3 (2.3)	2.3 (2.0)	2.5 (2.1)	3.8 (1.4)*	3.8 (1.4)*	5.47	0.0060
KPDS (Knowledge)								
Knowledge about depression	2.9 (0.6)	2.8 (0.6)	2.7 (0.9)	3.5 (0.8)	3.3 (1.1)	3.3 (1.0)	0.01	0.9967
How to prevent depression	2.6 (0.7)	2.3 (0.5)	2.2 (0.9)	2.5 (1.0)	3.3 (0.7)*	3.2 (0.8)*	8.08	0.0006
Possibilities for prevention	3.1 (0.8)	2.7 (0.8)	3.0 (0.8)	3.0 (1.0)	3.9 (0.3)*	3.7 (0.6)*	10.95	<0.0001
Seeing the doctor for treatment	3.3 (0.8)	3.3 (1.0)	3.3 (0.8)	3.6 (0.6)	3.8 (0.4)	3.8 (0.5)	0.50	0.6070
Using the advice center in the city hall	2.1 (1.2)	2.3 (1.1)	2.3 (1.0)	2.3 (1.3)	3.5 (0.6)*	3.3 (0.9)*	5.63	0.0052
Doing something for prevention	2.8 (0.9)	2.7 (0.9)	2.3 (1.2)	2.5 (1.2)	3.4 (0.7)*	3.0 (1.1)	4.87	0.0101
Self-efficacy in prevention	3.2 (0.7)	2.9 (0.6)	2.8 (0.7)	3.1 (0.9)	3.7 (0.5)*	3.4 (0.6)	5.58	0.0054

Note. Means and standard deviations are presented for participants for whome data were acailable at all time points as is the requirement for ANOVA, whereas effect size have been calculated on all available data for that particular time point. Pre = pre-intervention; Post = after intervention; SDS = Zung self-rating depression scale; FEQ = Fordyce emotions questionnaire; KDPS = Knowledge about depression and prevention of depression Scale. Interaction: A two-way repeated-measures ANOVA; *F, F-values; P, P-values.* $*p < 0.05$, $**p < 0.01$, vs. pre-value.

prevention.

An improvement was observed in total SDS scores in both the high-risk and low-risk groups. The effect was maintained one month after the completion of the program as indicated by the follow-up survey. In the high-risk group, physiological concomitants and psychological concomitants of depression were significantly improved. A characteristic of depression among older adults is that physical symptoms are likely to arise and there is a high correlation between mind and body. Therefore, the self-realization of psychological and dysautonomic symptoms are stronger. We believe that the program's focus on physical aspects such as adjustments in activity along with mood is what led to an increased rating of health in mind and body.

The study demonstrated an increased understanding concerning depression prevention in program participants. This indicates that psychological education that teaches participants to become aware of their own changes in mood and provides them with methods to manage those changes is an effective program. Problems associated with depression among older adults are that depression is likely to be overlooked as a byproduct of aging and it is prone to becoming more severe. Through the psycho-educational program concerning depression utilized in this study, participants realized the possibilities of depression prevention and gained knowledge concerning depression prevention. We believe that these factors can foster the prevention and early detection of depression. By providing information regarding the use of the advice center in the city hall, participants' inclinations to use the advice center to manage their changes in mood was increased. This could serve to prevent worsening depression in older adults.

We believe the effectiveness of the program indicated by the results is a product of the program being based on cognitive behavioral therapy methods and that support was provided by the coordination of various services in a comprehensive manner. Cognitive behavioral therapy is composed of elements that deal with holding a problem-solving mindset. This decreases the amount of time it takes to solve problems and makes it easier to increase motivation for treatment (Dahl, et. al., 2000). This program utilized this aspect of cognitive behavioral therapy and presented assignments for participants to incorporate changes based on the teachings of each session. Changes in each individual's experiences and behaviors within the daily lifestyle may have led to an improved mood. The cooperation between health service and social service specialists was critical in supporting the daily practice. It has been reported that medical and health support such as treatment, drug therapies, and psychiatric supervision as well as social support leads to early detection of depression and suicide prevention (Oyama, et. al., 2008). It is necessary for multiple professions to work together to provide all aspects of support for older adults. This study provided participants with knowledge regarding medical and welfare services as well as expanding on support, health counseling, and participation in society. The cooperation between welfare, health, and psychology specialists served as a foundation for the program's effects. This type of cooperative practice should also lead to the education of depression prevention for the specialists and increase their knowledge in such a specialized field.

Most improvements observed from pre-test to post-test were maintained through the follow-up. However, some improvements returned to initial values one month after the completion of the program. Among the high-risk group, "knowledge about depression" and "doing something for prevention" within the knowledge about depression prevention category and among the low-risk group, "psychological concomitants" within the SDS and "doing something for depression" and "self-efficacy in prevention" within the knowledge about depression prevention category fit the trend. It has been reported that there are no differences in the effects of psychological therapy among adults, but consideration should be given for programs aimed at older adults to compensate for declines in cognitive functioning such as a decrease in information processing speed and working memory function[32]. For the proper understanding and memorization of knowledge, repetition of instructions is necessary. This study shows that continued support to improve psychological symptoms for the high-risk group is needed and in order to measure the fixation of knowledge concerning depression prevention, long-term follow-ups on both groups are necessary.

Further investigation would involve the determination of long-term effects. There are reports that effects of cognitive behavioral therapy for depression decrease after a year (Cuijpers, 2004). Therefore, long-term follow-up data is necessary. A limitation of the study is that the groups were not randomly allocated. The effect of the intervention program could vary according to the physical health conditions of the participants. Further studies should consider the establishment of an experimental design.

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Summary

The aim of this study was to develop a comprehensive intervention program for improvement of mood and depression prevention through the maintenance of activities and behavioral initiatives in older adults. Participants were divided into high-risk and low-risk groups depending on the severity of their depression. Within each group, an intervention group and control group were created and scores on measurement scales were compared to determine the effect of the treatment. Surveys were conducted before, immediately after and one month after the six-session program. A comparison of results demonstrated that the program had an effect on depressed moods, happiness, and understanding of depression prevention. We believe that the psycho-educational program provided comprehensive support for all aspects of older adults' lifestyles and led to the effectiveness of the program.